State of Washington

A Section 1115 Demonstration Waiver Application

REQUIRING CERTAIN MEDICAL ASSISTANCE CLIENTS TO PAY PREMIUMS

Submitted by

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

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II. ABBREVIATIONS AND DEFINITIONS

ACES: *"Automated Client Eligibility System",* the automated single system that supports DSHS operations regarding client eligibility, issuance of benefits, and management support.

BH: ***"Basic Health Program,"*** adopted in 1987 as state-sponsored program providing affordable health coverage to low-income residents not otherwise eligible for Medicaid.

CMS: ***"Centers for Medicare and Medicaid Services,"*** (formerly **the Health Care Financing Administration)** the federal agency with the authority of waiver approval.

CN: ***"Categorically Needy"*** programs, which are federally matched and provide a broad scope of medical services for low-income aged, blind, or disabled persons, pregnant women, children and families and refugees. CN clients are often recipients of financial assistance also.

CDPS: "***Chronic Illness and Disability Payment System,"*** the system used to adjust capitated payments for Medicaid beneficiaries, and the system that will be used to monitor waiver implementation.

DSHS or Department: ***"Department of Social and Health Services,"*** Washington's umbrella human service agency that includes the Medical Assistance Administration (MAA)—the state's Medicaid agency. DSHS is designated as the "single Medicaid agency" as required by federal law, and is the official Waiver applicant.

EPSDT*: "Early and Periodic Screening, Diagnostic, and Treatment,"* mandatory comprehensive and preventive health services for Medicaid eligible individuals under the age of 21.

First Steps: Washington's Medicaid program for low-income pregnant women with family income at or below 185 percent of FPL.

FPL: ***"Federal Poverty Level,"*** a commonly used reference for the federal "poverty guidelines," which are adjusted annually and used as a Medicaid eligibility factor, e.g. First Steps eligibility is partially based on a FPL of 185 percent ($28,231 for a family of three).

HCA: ***" Health Care Authority,"*** the state agency that administers public employee benefit plans and the Basic Health Program.

HCFA: ***"Health Care Financing Administration,"*** the former title of CMS.

Health carriers: Health maintenance organizations (HMO's) and risk-bearing preferred provider organizations (PPO's) licensed as insurers in Washington State.

HIFA: ***Health Insurance Flexibility and Accountability*** demonstration initiative, an expedited section 1115 waiver approach designed to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage within current-level resources.

Healthy Options: Washington's Medicaid Managed Care Program, which contracts for comprehensive Medicaid services through health carriers.

HWD: **"*Healthcare for Workers with Disabilities,"*** Washington's version of the federal ***"*Ticket to Work*"*** program providing Medicaid services to low-income disabled workers.

MAA: ***"Medical Assistance Administration,"*** the entity within DSHS administering the acute and chronic portions of the state's Medicaid program.

Medicaid: Title XIX of the SSA--the state and federally funded aid program that covers the Categorically Needy (CN) and Medically Needy (MN) programs.

MMIS: ***"Medical Management Information System,"*** which accurately processes claims for clients eligible for medical assistance and other programs.

Premiums: A monthly payment requirement for the receipt of a set of prescribed health services.

MN: ***"Medically Needy"*** programs, which provide Medicaid services to aged, blind, or disabled persons, pregnant women, children, and refugees with income and resources the same as the CN limits.

RCW: ***"Revised Code of Washington"***—Washington State's law, e.g. RCW 74.09.055 authorizes the premium provision in this waiver.

Section 1115 (of SSA) Waiver: Authority granted to states by CMS for experimental, pilot, or demonstration projects, e.g., charging clients premiums.

SCHIP: ***"State Children's Health Insurance Program,"*** Title XXI of SSA-- health services at a federal matching rate higher than Medicaid for children with family income between 200 percent and 250 percent of FPL, and undocumented pregnant women.

SFY: ***"State Fiscal Year"*** in Washington State—July 1st to June 30th.

Social Security Act (SSA): United States' major human service law, which includes several health-related titles: Title XVIII (Medicare), Title XIX (Medicaid) and Title XXI (SCHIP).

Take Charge: Washington's 1115 Medicaid demonstration program that provides family planning services to both men and women with family income at or below 200 percent of FPL.

Title XVIII: Medicare Title of the SSA

Title XIX: Medicaid Title of the SSA

Title XXI: SCHIP Title of the SSA

TANF: ***"Temporary Assistance for Needy Families,"*** the federal welfare reform program that replaced the Aid to Families with Dependent Children (AFDC) Program. TANF is referred to as **Work First** in Washington State.

WAC: ***Washington Administrative Code***—Washington State's rules and regulations.

Waiver Demonstration Population: The Medicaid client group(s) affected by the waiver provisions.

III. EXECUTIVE SUMMARY

Washington State is requesting an 1115 demonstration waiver to require premiums for Medicaid coverage of Medicaid Categorically Needy (CN) optional children. The Washington State Legislature has directed DSHS to obtain an approved waiver by September 2003 and to implement the premium program by January 2004 for service coverage beginning February 2004. These provisions will promote the long-standing state policy of individuals and families contributing toward the cost of their medical coverage, help sustain coverage for children in moderate-income families, and provide important information for future program development.

This waiver application is the third formal version of an application process that began in November 2001 with a broad health reform proposal. The current waiver proposal represents extensive discussions with CMS officials over the past two years. The current proposal is limited to waiving Section 1902(a)(14) and 1916 of SSA in order to adopt premiums for CN optional children in families with incomes above 100 of FPL. The premium amounts are designed to be no greater than 3 percent of family income, which is within the 5 percent limit set forth for SCHIP, HIFA waivers and agreed to by CMS for this request.

To ensure that the demonstration achieves its objective and to support the demonstration, the Department intends to implement a comprehensive monitoring of the premium program. This monitoring will provide CMS and state policy makers with information on the impact of premiums on both program participation rates and the impact on the program's risk pool. Washington is in a unique position to monitor these parameters because of the extensive analysis and available data used for caseload monitoring and forecasting, and because it already risk-adjusts rates for health status within its managed care program.

Although other states have implemented SCHIP premium programs for children's coverage for families in similar income levels, Washington's demonstration proposal is unique in that it proposes to impose premiums on a Medicaid population that has not been required to pay premiums for their children's coverage. This demonstration will provide valuable information to federal and state policy makers as they continue to modify their Medicaid programs to address fiscal constraints and to continue Medicaid reforms. Moreover, this waiver request for premium adoption is consistent with both the National Governors' Association's (NGA) and the Secretary of Health and Human Services (HHS) Medicaid reform proposals.

IV. STATUTORY AUTHORITY

A. Federal Law

Washington State is seeking an 1115 demonstration waiver in order to implement premium requirements for Medicaid coverage for Categorically Needy (CN) optional children:

1) SEC. 1902. (a) (14) -- Title XIX SSA (*42 USC. 1396a)*
2) SEC. 1916. (a) (1) -- Title XIX SSA (*42 USC. 1396o)*

Establishing conditions for the imposition of premiums and other cost-sharing requirements.

B. State Law

The Washington State Legislature recently enacted the following legislation:

1) SB 5404 (209(20)[2003-05 Biennial Budget]

Directs the DSHS to secure a federal waiver, effective no later than September 1, 2003, which will enable it to charge premiums for medical and dental coverage of children whose family incomes exceed the federal poverty level.

2) RCW 74.09.055 (Amended in 2003 by HB 2285)

Expands DSHS' authority to establish premiums and "**other cost-sharing"** requirements for recipients of any medical programs defined in RCW 74.09.010.

V. WASHINGTON'S MEDICAID GROWTH

Washington's Medicaid client population has grown significantly during the previous two decades, in correspondence with federal expansion opportunities[1]. Most of the caseload increases during this period were in categories of children and family planning (categories with generally lower utilization). Future growth is anticipated for aged, blind and disabled clients (categories with higher utilization).

Program and expenditure growth is associated with eligibility and benefit expansions, and with a number of recent economic and demographic changes, e.g., declining private health insurance enrollment, the growing number of Medicaid dual eligibles, the rising drug costs, and the growing number of low-wage workers whose employers do not provide coverage.

All of these factors have created pressure on the state to shelter more people under the Medicaid umbrella. Today, one in three Washington children is covered by Medicaid, which also provides coverage for more than 40 percent of the births in the state. Medicaid covers 14 percent of all Washington residents. All this has led to client enrollment increasing 125 percent since 1990.

Rapid growth in Medicaid enrollment has been matched in recent years by substantial increases in medical costs. Although the federal government pays about half of the costs, the state's share has been rising as much as $150 million in a year (This amount excludes Disproportion Share (DSH) funding and so-called higher-limit reimbursements, referred to as Proshare.) Currently MAA is projected to spend $3.5 billion in non-federal funds this biennium.

As MAA's costs rose overall, its programs began to compete with other state services for funding, especially education, which has long been identified as the primary governmental function in this state. Today, Medical Assistance expenditures from all sources represent a full 13 percent of the state budget and Medical Assistance accounts for approximately 14 percent of the growth in the 2003-2005 budget from the prior biennium.

Where the challenges in the past were daunting, those in the present and future seem even more ominous. General health care cost increases will continue to outstrip other economic segments for some time into the future projected at 10 percent per year for the better part of this decade. While these increases are partially associated with medical inflation, traditionally running above general inflation, they are also due to a greater

[1] In 1989, children to age 8 up to 100 percent of FPL; and pregnant women up to 185 percent of FPL (First Steps); 1990, children aged 1 to 5 up to 133 percent of FPL; 1991, insurance coverage for certain AIDS patients; 1992, children to age 19 up to 100 percent of FPL; 1994, children to age 19 up to 200 percent of FPL; 2000, children to age 19 from 200 percent to 250 percent (SCHIP); 2001, women with breast and cervical cancer up to 200 percent of FPL; 2001, family planning for men & women up to 200 percent of FPL (Take Charge); and 2002, Healthcare for Workers with Disabilities (HWD) up to 220 percent of FPL.

extent to increases in service utilization, i.e., more drugs and therapies are being provided and the new ones tend to be more expensive. This is of great concern because while inflation can be periodically checked, the explosion in the development of therapies, drugs, and devices, and their subsequent use, seems unstoppable. State revenue sources that support Medical Assistance are growing much more slowly than anticipated. With a recession and spending limits, state economists predict continued declines before the state sees an upturn.

VI. CHILDREN'S CASELOAD GROWTH

Washington State has been a national leader in expanding health care coverage to children. In the late 1980s, Washington began to implement a series of medical care coverage expansions for children. In 1989, the State Legislature enacted the Maternity Care Access Act of 1989. This act authorized DSHS to expand Medicaid coverage and provide comprehensive prenatal care coverage to pregnant women and infants with incomes up to 185 percent of FPL under a new program called First Steps.

In January 1991, DSHS implemented the Children's Health Program to provide coverage to children under age 18 who were in families with income up to 100 percent of FPL. The state's Medicaid program was already covering children through age 5 in families up to 133 percent of FPL. The Children's Health Program was converted to Medicaid funding in January 1992, and the age limit was raised through age 18.

Children not meeting Medicaid citizenship requirements continued to receive coverage through the Children's Health Program. When this program was terminated in 2002, it had offered health care to some 22,000 children who did not qualify for Medicaid before the program was terminated in 2002.

In July 1994, the Medicaid children's program was further expanded to 200 percent of FPL. This expansion was part of comprehensive health reform legislation that was intended to require that all residents be enrolled in health insurance. The reformed system would continue to be based on employer-sponsored coverage. However, the state would provide subsidized coverage to residents up to 200 percent of poverty.

Prior to enactment of SCHIP, Washington was one of only four states with optional Medicaid coverage at or above SCHIP's target coverage of 200 percent of FPL. In February 2000, Washington extended coverage up to 250 percent of FPL through SCHIP. Washington is one of ten states with children's coverage at or above 250 percent of FPL.

Currently, Washington's Medicaid program provides coverage to 556,700 children (see Table One). This is 35 percent of all children in the state. Some 179,700 children received coverage through TANF Medical coverage; 15,400 were disabled children receiving SSI assistance; 190,200 were covered through the Medicaid mandatory children's program; and 162,200 were covered through the Medicaid optional program.

These coverage expansions and eligibility innovations have played a key role in reducing children's uninsured rates. Based on the most recently available data, Washington's

children had an uninsured rate of 8.6 percent in 2002.[2] The national uninsured rate for children below 200 percent of FPL was 14.9 percent.

It is anticipated that Medicaid coverage for children will continue to increase. The primary trend forecast for the Medicaid children's program was estimated to increase 7.5 percent per year over the next two state fiscal years (July 2003 through June 2005) (see Table Two). With the implementation of more stringent eligibility reviews and implementation of premiums, the program is still estimated to increase at about 2.4 percent per year. By the end of next biennium the Medicaid children's program will have increased from 353,000 to 377,000 children per-month.

VII. CHANGING POLITICAL ENVIRONMENT

Historically, Washingtonians have easily accepted expanding roles of government and the corresponding revenue outlays in order to address emerging public problems and provide necessary human services, as demonstrated by Medicaid expansions mentioned above. However, in recent years there has been a significant shift in the public attitude toward human services with citizens showing greater reluctance to expand public entitlements or provide the needed funding.

Washington's delay in participation in the SCHIP program illustrates this change. In past decades Washington would have been one of the first states to participate. In fact, despite the program being created in 1998, Washington did not join until 2000 and was one of the last states to do so. This delay was not due to the lack of revenue, but to a growing belief that families with income in excess of 200 percent of poverty should not receive public subsidies for their children's health coverage.

A greater demonstration of this emerging fiscal conservativism is found in public approval of several initiatives that limit the growth of public expenditures and reject greater investment in traditional segments of the state's infrastructure, such as for public transportation.

VIII. RECENT LEGISLATIVE ACTION

This fiscal conservatism has been further enhanced by the state's recent budget crisis producing a $2.6 billion shortfall in a $23 billion biennial budget. And although the budget was recently adopted without revenue enhancements, soon after that adoption an additional $150 million shortfall has been forecasted for the 2003-2005 biennium.

To help address this budget crisis, the Legislature took several steps to reduce state health care expenditure growth. It required state health agencies to establish a joint drug purchasing process, develop a centralized process for evidence-based health technology assessments, and reduce the unnecessary administrative requirements of providers, hospitals, and insurers. It strengthened the Medicaid client eligibility verification process

[2] Source: 2002 Washington State Population Survey. Washington State Office of Financial Management.

by requiring semiannual reviews. It reduced the scope of dental services for adults, required nominal copayments for durable medical equipment, tightened eligibility requirements for medical care related to general assistance, and reduced the BH enrollment by over one-third. The legislature also eliminated funding for emergency medical care for low-income, uninsured persons by eliminating the Medically Indigent (MI) program. The elimination of this program resulted in over $100 million in state fund savings for this coming biennium.

The Legislature also directed MAA to implement a premium requirement consistent with this Waiver application. The imposition of premiums on Medicaid clients is viewed by policy makers not only as a cost-cutting measure, but also as part of the broader strategy to improve the efficiencies and effectiveness of state health care programs.

The public's stringent attitude about public expenditures, the ongoing fiscal crisis, and the legislative call for greater efficiency clearly require new directions in the way states purchase and provide health care for persons in need of public coverage. This is further echoed in proposals put forth by the National Governors' Association and the Council for State Legislatures, and the Medicaid reform efforts being developed by the Secretary of Health and Human Services.

IX. PREVIOUS WAIVER EFFORTS

A. NOVEMBER 2001 WAIVER SUBMISSION

1) Washington's Request

In anticipation of continued budgetary restraints and rising health costs, DSHS submitted its Section 1115 demonstration waiver application to CMS in November 2001. Its purpose was twofold: (1) To avoid the need to eliminate Medicaid client eligibility groups and (2) to help sustain the state's effort to provide health coverage to low-income children, families and childless adults. This waiver was unique because, unlike other waivers which requested specific changes to the Medicaid program, it sought flexibility in certain program areas in order to provide the Legislature and Governor with a "tool box" to make future modifications so as to maximize flexibility and control costs. In addition to the "tool box," the following specific provisions were sought:

- The use of premiums for all Medicaid clients with incomes above poverty, as long as total cost sharing did not exceed 5 percent of the family's income on average.

- The use of copayments above a nominal amount for Medicaid clients for all non-preventive care services, along with the authority to permit providers to deny non-emergent services if a client was unwilling to pay the copayments.

- Flexibility to establish different benefits for optional Medicaid coverage groups, including children.

- Authority to impose an enrollment freeze on optional Medicaid coverage groups when projected caseloads exceed appropriations.
-
- The use of a "presumptive" budget neutrality assurance methodology.

- The use of the state's unspent SCHIP allotment funds to expand Basic Health (BH) program coverage to parents of Medicaid and SCHIP children and possibly to childless adults.

2) CMS' Response

In a January 2002 letter, CMS responded expressing its concerns over the lack of specificity in the application, identifying major issues due to the absence of details. More specifically, CMS indicated that:

> It would not permit the denial of services for non-payment of a copayment; however, it would permit providers to substitute services, e.g., a less expensive generic drug, if the client did not pay the copayment.
>
> Premiums for optional eligibility groups would be permitted consistent with the 5 percent cost-sharing limitation.
>
> It would allow for benefit design flexibility for optional Medicaid populations and SCHIP-eligible children.
>
> An enrollment freeze may be permitted, but more specificity would be required on which CN optional and Medically Needy (MN) eligibility groups would be included in the demonstration population.
>
> The use of the state's unspent SCHIP allotment to cover childless adults was permissible, but eligibility should be limited to families and adults with incomes below 200 percent of poverty.
>
> DSHS would be more successful if it were to use the new Health Insurance Flexibility and Accountability (HIFA) demonstration initiative for its application, which is easier to complete and process, instead of continuing with the initial Section 1115 demonstration waiver application.

B. AUGUST 2002 WAIVER RE-SUBMISSION

1) Washington's Request

Taking into consideration CMS's concerns, Washington resubmitted the application on August 12, 2002 using the HIFA template, as recommended, and specifying the major provisions as follows:

- **Copayments:** In order to encourage appropriate use of target services, all Medicaid clients would be required to pay: (a) $5 copayments if they use a

higher-priced brand-name drug when a lower-cost equivalent medication is available, unless their provider indicates the brand-name drug is medically necessary; (b) $10 copayments if they seek non-emergency treatment at hospital emergency rooms (ER). While providers will not be able to deny services for non-payment of the co-payment, pharmacists will be able to substitute generic or therapeutically equivalent preferred drugs if the provider's order allows for substitution. Providers must get MAA "medically necessary" approval in order for the pharmacist to be paid the brand-name drug price.

- **Premiums:** Clients with income above poverty in optional Medicaid programs will be required to pay small premiums representing no more than 5 percent, on average, of a family's income. American Indians and Native Alaskans would be exempt from these copayments and premium requirements.

- **Benefit Design Changes:** Benefits for adults in optional Medicaid programs will be more similar to those of BH with the addition of outpatient therapies and durable medical equipment. Services that would not be covered include non-emergent dental care, hearing care and hearing aids, and eyeglasses and exams.

- **Enrollment Freezes:** An enrollment "freeze" and waiting list will be imposed to permit the program to stay within funds appropriated. The freeze would apply only to certain optional Medicaid groups, but not to clients in transition from one program to another. The enrollment freeze would be imposed when the total Medical Assistance caseload is projected to exceed the expenditure levels assumed by the Legislature for that fiscal year.

- **Unspent SCHIP dollars:** The use of the state's Title XXI SCHIP funding allotment to expand BH coverage to parents and childless adults. Coverage would be limited to persons and families with incomes at or below 200 percent of FPL.

2) CMS' Response

CMS indicated that co-pays could not apply to mandatory populations. This prohibition would exempt 77 percent of clients from the requirement, which would substantially weaken the provision, if not render it useless.

CMS prohibits an enrollment freeze on all Medicaid children's client groups. The waiver envisioned the freeze applying to optional children groups. This restriction would limit the freeze imposition to less than two percent of our clients.

CMS indicated that it was prepared to allow for the imposition of premiums for optional Medicaid clients with incomes above 100 percent of FPL, provided the premiums did not exceed 5 percent of income.

CMS also specified it would approve elimination of dental, vision and hearing services for optional CN Medicaid Buy-In and Medically Needy adults.

CMS indicated that to use unspent SCHIP funding to expand BH in Washington would require maintenance of effort (MOE) based on the 2003 BH enrollment level of 125,000, regardless of possible reduction in BH enrollment as the result of legislation.

X. CURRENT WAIVER SUBMISSION

A. Modifications to Date

As the result of responses with CMS and ongoing consultations with the Governor, key legislators, and stakeholder groups, the Department is making the following changes to the waiver request provisions:

- Delete the copayments provision because the benefits of this provision, as permitted by CMS, would be minuscule, and the implementation of the E.R copayment is problematic.

- Delete the benefit modification provision because this issue has been addressed by the Legislature in its recent session.

- Defer the request for use of the unspent SCHIP to expand BH capacity until the program enrollment has been modified per the recent statutory reduction.

- Pursue the premium provision as clarified below.

B. Premium Requirements for Children in Optional Groups

1) Rationale

The sole programmatic purpose of this waiver application is for permission to charge non-nominal premiums for CN optional children's coverage in families with income greater than the FPL. Client cost-sharing through premiums has been part of benefit coverage for decades. Most health analysts agree that, properly designed, premiums can deter unnecessary utilization of services, encourage personal responsibility, and defray purchaser's benefit costs. Also, if inappropriately designed, they can discourage enrollee participation in coverage and be a barrier to needed health services.

Although studies have been conducted on the impact of cost sharing on insured persons, we have little research on the effects of imposing of premiums on Medicaid low health service-utilizing clients, e.g., children, in higher income levels. In this demonstration, the concerns about possible negative effects of imposing premiums upon Medicaid clients will be taken seriously. For that reason, the demonstration will be implemented prudently, encompassing a comprehensive evaluation as described below.

C. Low-Income Premiums: Washington's Experience

Although the imposition of premiums would be new to the proposed demonstration population, similar requirements of low-income families have been in effect in Washington since 1988 and are frequently discussed by policy makers, as indicated in the following:

Basic Health: In 1988, the Basic Health (BH) Program began. BH is a state-sponsored program that provides affordable health coverage to low-income Washington residents with family income at or below 200 percent of FPL. Monthly premiums range from $10 to $158 and are based on family size, income, age, and the health plan selected. State funds will be used to help pay a portion of the monthly premium. To qualify, applicants must meet BH income guidelines, live in Washington State, not be eligible for free or purchased Medicare, and not be institutionalized at the time of enrollment.

Section 1931--Title XIX: In February 2002, MAA began charging premiums for medical coverage in the second six months of Medical Extension Benefits (MEB) for families who began receiving benefits in February 2002 or after. These premiums are imposed as allowed under Section 1925 of the SSA and as required by the 2001-03 Federal Omnibus Operating Budget. If the average family income is under 100 percent of FPL, the household is exempt from the premium requirement. The premium for each caretaker adult equals 1 percent of the average countable income; for example: one percent of $1383.33 equals $13.83, which is rounded down to $13.00 per month/per adult.

HWD: In January 2002, MAA implemented the "**Healthcare for Workers with Disabilities"** program described in WAC 388-475-1000. This program expanded Categorically Needy (CN) Medicaid to people with disabilities (age 16 through 64) who want to work and have countable income at or below 220 percent of the federal poverty level (FPL). The monthly premium for HWD is based on a formula of roughly 7.5 percent of a client's total income.

SCHIP: In March 2000, SCHIP clients began to pay premiums. Premiums are $10 per child per month, with a family maximum of $30 per month for three or more children. American Indian and Alaska Native clients are exempt from premiums.

1993 Health Reform: In 1993, Washington State adopted the most comprehensive state reform effort to date. It included universal access by 1999, employer mandates, a uniform benefits package, certified health plans and insurance reforms. The Act was never implemented because statutory authority to require employers to contribute to worker coverage was not forthcoming from the U.S. Congress. However, the commission charged with implementing that Act had developed draft rules regarding low-income premiums that recommended premium levels up to 3.4 percent of income for enrollees at 150 percent of FPL and 5 percent of income for enrollees at 200 percent of FPL.[3]

[3] Draft WAC 254-03-570 (not promulgated), Washington Health Services Commission, January 1995

1997 Legislature: In 1997, the Legislature required the Department to "seek federal approval to require adult Medicaid recipients who are not elderly or disabled to contribute ten dollars per month toward the cost of their medical assistance coverage,"[4] which assumed a budget savings of $11.5 million in total funds for SFY 1999. Although the provision was supposed to be implemented by July 1, 1998, the Health Care Financing Administration (HCFA) indicated it would not approve the necessary waiver to do so.

D. Low-Income Premiums: Other States

The advent of the SCHIP program has resulted in the imposition of low-income premiums in 24 states. While none charge premiums at levels proposed in Washington's Waiver application, thirteen states require premiums of families with income as low as 150 percent of FPL: Alabama, Indiana, Illinois, Iowa, Kansas, Massachusetts, Maine, Michigan (150 percent-200 percent $5 Per family per month (PFPM), Nevada (125 percent-150 percent $10 Per family per quarter (PFQ), 151 percent-175 percent $25 PFQ, North Carolina, New Jersey, New York, Rhode Island. Six states require premiums of families with incomes as low as 100 percent of FPL: California, Delaware, Georgia (100 percent-235 percent $7.50 PMPM), Florida, Texas and Utah. [5] In January 2002, Rhode Island increased premium amounts for clients in the 150 percent to 250 percent FPL range from 3.4 percent to 4 percent of family income[6].

XI. WAIVER PREMIUM POLICY ELEMENTS

A. Medicaid Clients Affected

- The 2003-05 Biennial Budget Act (SB 5404) requires the DSHS ***" to charge co-premiums for medical and dental coverage of children whose family incomes exceed the federal poverty level."***

- More specifically, premiums will be required of the following:

- CN optional children under age 1 whose family income exceeds 185 percent FPL

- CN optional children age 1 through age 5 whose family income exceeds 133 percent FPL

- CN optional children age 6 through age 18 whose family income exceeds 100 percent FPL

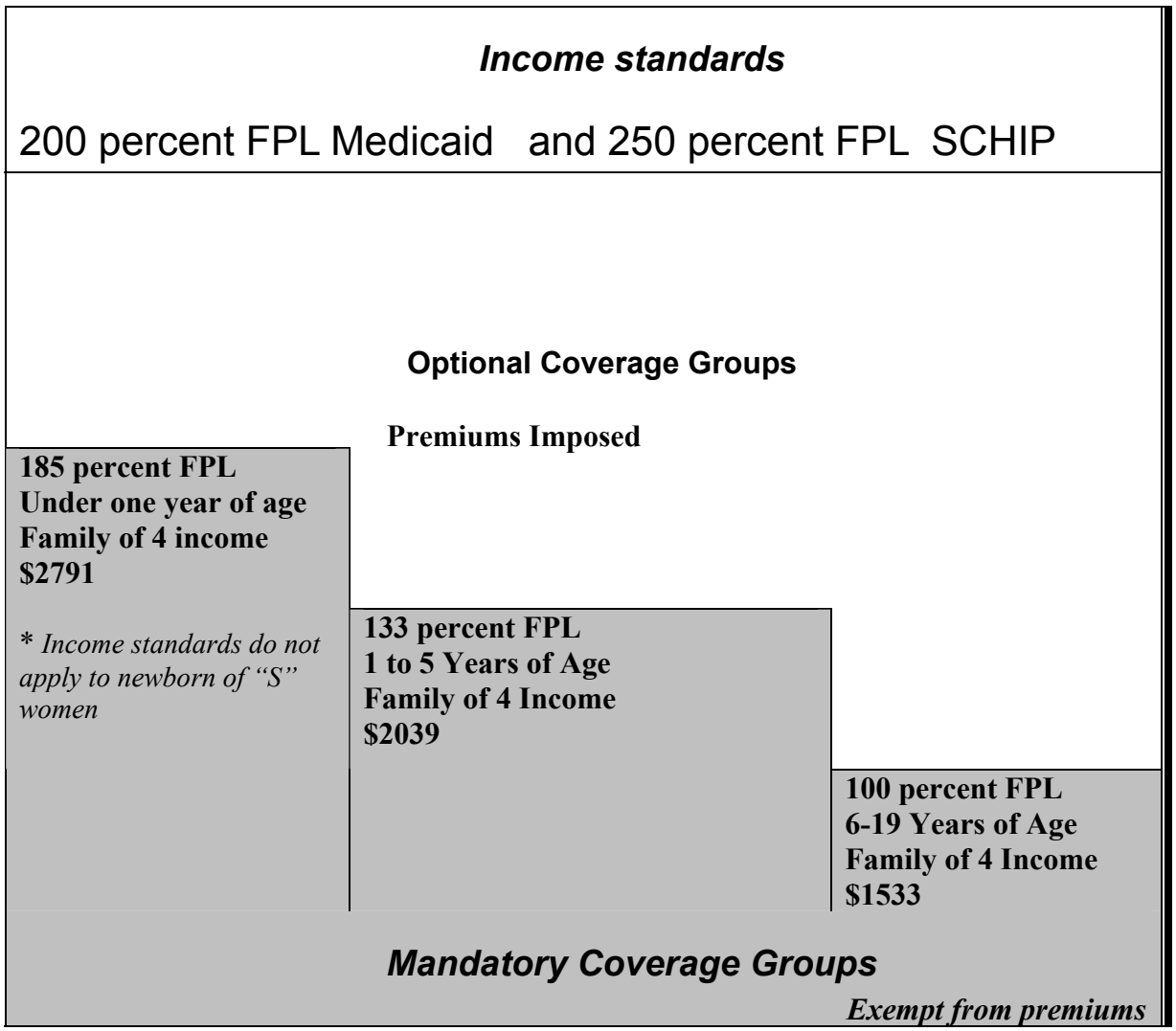
[4] 1997-99 Biennial Budget Act, SB 6062 (209)(7)
[5] National Academy for State Health Policy survey, July 2002

[6] **Fact Sheet on RIte Care and RIte Share Family Premiums**, Rhode Island Department of Human Services, June 2002

B. Medicaid Clients Exempted

- All mandatory Medicaid populations, including foster care and adoption.
- Optional children whose family countable income is under 100 percent FPL
- Pregnant children
- American Indian/Alaska Native clients
-

The following chart illustrates affected clients:



C. Premium schedule

The corresponding **2003-05 Biennial Budget Detailed Notes** set forth the premium parameters as follows:

Premium amount:

Band A $15.00 Net available income is above 100 **percent** FPL but at or under 150 **percent** FPL

Band B $20.00 Net available income is above 150 **percent** FPL but at or under 200 **percent** FPL

Band C $25.00 Net available income is above 200 **percent** FPL (SCHIP Clients) but at or under 250 **percent**

A family will be billed for the children with the three highest premiums. The maximum premium for a family of three or more children is $75.00 per month.

Premium amounts will not exceed 3.0 percent of family's gross income.

The premium amount is established using the net available income to the children. Premium computations are summarized in **Exhibit C**.

The parent designated as the head of household will be sent one premium bill for the "rolled up" premium amount

D. Premium Arrears and Termination

The optional children in a family will lose Medicaid or SCHIP eligibility when the family owes all or part of the premium obligation for three months. A family is three months in arrears when the family has:

- Not made any payment for three months; or
- Made partial payment but still has a past due balance for each of the last three months.

This policy is described in the following three examples:

Example 1 Family is billed $20 per month and consistently pays $0.			
Month	**Billed**	**Paid**	**Balance Due**
1 – November	$20	$0	$20
2 – December	$20	$0	$40
3 – January	$20	$0	$60
The family is three months in arrears and the child is terminated at the end of January			

Example 2 Family is billed $20 per month and consistently pays $5.			
Month	**Billed**	**Paid**	**Balance Due**
1 – November	$20	$5	$15
2 – December	$20	$5	$30
3 – January	$20	$5	$45
* All payments have been applied to the November premium bill (the earliest unpaid month) but a past due balance exists for each of the three billing months. The family is three months in arrears and the child is terminated the end of January.			

Example 3 Family is billed $15 per month and payment varies.			
Month	**Billed**	**Paid**	**Balance Due**
1 – November	$15	$0	$15
2 – December	$15	$15	$15
Note: December payment is applied to the November past due amount			
3 – January	$15	$7	$23
Note: January payment is applied to the December past due amount.			
4 - February	$15	$0	$38
* The family is three months in arrears. A past due balance exists for December, January and February. The child is terminated the end of February.			

A child whose Medicaid or SCHIP eligibility is ended due to non-payment of premiums is ineligible for three months.

E. Reinstatement

After the three month period of ineligibility is over, the child can be eligible only upon payment of all past due premiums.

Examples:

- A child is terminated June 30 for non-payment of premiums. The period of ineligibility is July, August and September. The family pays the past due premiums in July and applies for the child in September. The child is eligible October 1—the earliest date after the end of the period of ineligibility.
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- A child is terminated June 30 for non-payment of premiums. The period of ineligibility is July, August and September. The family applies for the child October 15 and is advised they must pay the past due premiums. They pay all past due premiums on November 1. The child is eligible October 1.

- Past due premiums remain a debt for twelve months. After twelve months, the past due premiums are written off.

- If a child later becomes mandatory, the period of ineligibility and past due premium obligation is waived.

F. Retroactive Eligibility

Premiums will not be charged for a period of retroactive eligibility or for the month of application. However, the client will not be retroactively eligible for a month included in the period of ineligibility established due to non-payment of premiums.

G. Benefit Coverage

The Demonstration includes no benefit changes.

H. Sponsorships

Partial or full payment of premiums by employers, providers, and non-providers are permitted.

XII. FINANCES

A. Program Implementation

Costs of implementing the premium requirements are mostly associated with the hiring and training of community service staff regarding eligibility, and premium billing and collections. Figures show total funding.

	SFY 2004	SFY 2005	TOTAL
Staffing	$1,884,699	$ 1,698,493	$3,583,192
Billing & Collections	$773,575	$1,117,150	$1,890,725

B. Budget Savings

In its budget assumptions, the Legislature assumed an annual average disenrollment of 3,034 for SFY 2004 and 19,373 in SFY 2005. Figures show total funding. For details see Exhibit A.

	SFY 2004	SFY 2005	TOTAL
Premium Revenue	$9,235,493	$25,201,110	$34,436,603
Lower Caseload Savings	$4,233,529	$28,588,282	$32,821,812

C. Budget Neutrality

The Department makes assurances that its demonstration Waiver comports with CMS requirements that the demonstration Waiver will not result in an increase in federal costs compared to costs in the absence of the demonstration. These assurances can be made because of the unique nature of Washington's demonstration. Unlike most demonstration waivers, Washington does not propose to cover any services that are not otherwise allowed currently and matchable as Title XIX State Plan services. The demonstration also would not cover eligibility groups that are not otherwise allowed currently and matchable as Title XIX State Plan optional coverage groups. Moreover, the programmatic changes requested in the Waiver would reduce the costs that the federal and state governments would otherwise incur without the demonstration. The adoption of premium requirements would reduce the per capita costs for eligibility groups covered under the demonstration below what would be expected without the demonstration.

The Department has been negotiating with CMS on an acceptable methodology to demonstrate budget neutrality. DSHS has been advised that the Office of Management and Budget (OMB) and CMS are prepared to grant a demonstration waiver only if it comports with so-called per-capita cap requirements.

Under this model, Washington will be required to establish a "base year", which is based on a recent 12-month period prior to the approved waiver, for the experience of the eligibility groups that are subject to the demonstration waiver. (See Table Four) For Washington, this would be Medicaid CN optional children.

This per-capita would be trended forward for each year of the waiver. We understand that the yearly trend factor will be based on a comparison of five years of historical data for Washington and the President's Budget Medicaid baseline for the eligibility groups covered by the Waiver.

Budget neutrality will be achieved so long as the state's actual per-capita for each eligibility group covered by the Waiver for a given year in the waiver period times the actual caseload for that eligibility group summed for each eligibility group in the waiver,

is less than the baseline per-capita adjusted for that year's trend factor times the actual caseload for that eligibility summed for each eligibility group in the waiver.

There will be annual assessments of the state's spending for the waiver groups. However, budget neutrality will be assessed over the five-year life of the waiver.

As a condition for approval, Washington will agree to the above per-capita capped model. Exhibit A includes the CN optional children calendar year (CY) monthly per-capita for CY02. This per-capita includes medical care and mental health care expenditures for these children.

Exhibit B includes CN non-grant children's expenditures for the five-year period from CY 1998 through CY 2002. The average annual per-capita growth rate is 7 percent. Although there have been significant yearly variances in per-capita growth rates, the 6.0 percent rate is consistent with the projected growth rate over the next two years.

Given the nature of Washington's Waiver, the base-year per-capita used to evaluate without waiver expenditures will not be reduced for the demonstration premiums. However, the actual per-capita used to measure with waiver expenditures will reflect gross expenditures minus the premium. The total expenditures used to claim federal financial participation will be offset for actual premium amounts collected by the state. This will assure that both the federal and state government benefit from families' financial participation for their children's health coverage.

XIII. ANTICIPATED CLIENT IMPACT

A. Service Delivery

The 2003-2005 budget anticipates that approximately 20,000 (10 percent) of the affected population will disenroll. However, there should be no changes in service delivery for the remaining clients resulting from this demonstration.

B. Service Access

No changes in service access are anticipated resulting from this demonstration.

C. Service Quality

No changes in service quality are anticipated resulting from this demonstration.

XIV. WAIVER-RELATED RESEARCH

A. Current Research

Research to-date has indicated that low-income individuals are more vulnerable to the adverse effects of general cost sharing than are other groups. However, until recently

most of the cost sharing research has focused on copayments. It was not until the advent of SCHIP that analysts began to look at premiums. Although much of this work is just underway, there are some research findings indicating a definite impact of premiums upon enrollment. An Urban Institute study estimated declines in enrollment of 16 percent when participants are charged premiums that equal one percent of family income, enrollment declines of about 49 percent if premiums equal three percent of family income, and enrollment declines of about 74 percent if premiums are set at five percent of family income. Similarly, the General Accounting Office found participation in state pharmacy assistance programs fell sharply in states that increased premiums for those programs. Research in Florida found that premiums encourage healthier participants to drop off the program, causing average health care costs to climb since those who remain on the program are less healthy, on average[7]. While one should not assume similar results with the demonstration population in this waiver, these initial findings do provide a strong reason for extensive investigations.

B. Waiver-Related Data Collection and Studies

In general, the key policy question is: Can the premiums be required of the demonstration population in a manner that controls costs, promotes appropriate client participation in the cost of their care, and maintains or improves the health status of that client group?

To answer that question: Waiver monitoring and evaluation must examine disenrollment patterns, client health status, ethnicity, geography, caseload trends, and changes in client risk profiles.

To address these policy needs, monitoring and evaluation processes will be created.

1) Monitoring

Monitoring will establish a real time tracking of client activities during the demonstration period. For client tracking data, the ACES eligibility system and the MMIS information system will be used. Telephone surveys will be employed to elicit information for disenrolled persons. For changes on client risk profiles, the Chronic Illness and Disability Payment System (CDPS)[8] will be used. This is presently employed by MAA to risk-adjust its Healthy Options population based on health status. Table 3 indicates the detailed questions, data sources, and collection frequency.

2) Evaluation

To evaluate the demonstration, a broader strategy will be used. As previously indicated, the Basic Health (BH) Program may provide a unique insight into

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[7] Leighton Ku ***"Charging the Poor More for Health Care: Cost-Sharing in Medicaid,"*** Center For Budget and Policy Priorities, May 7, 2003

[8] The CDPS was developed in 1996 Richard Kronick, and other s with the Department of Family and Preventive Medicine, University of California, San Diego for states to use in adjusting capitated payments for Medicaid beneficiaries.

premium impact because it has been charging premiums of populations similar to those in this demonstration for over 15 years. This opportunity is enhanced because BH is undergoing major changes in its benefit design, including premiums levels. The State Health Care Authority (the agency that administers the BH programs), MAA, and the Governor's Health Policy Office are exploring possibilities of a joint research venture to evaluate impacts on all low-income programs that charge premiums. Grant funding is being pursued for the project. [9] Further, this approach is supported within the Legislature, where consolidation of the two programs has been under consideration.

A major part of this endeavor involves convening a technical assistance meeting, composed of national and state health policy experts, to design a formal evaluation of Basic Health, Medicaid, and SCHIP program cost-sharing changes scheduled for 2004 and beyond. Based on outcomes of the technical assistance meeting, research assistance will be provided for planning and designing a comprehensive evaluation of program changes.

XV. WAIVER'S PUBLIC PROCESS

A. Goals

The Department believes that Washington residents have a legitimate interest in learning about Medicaid reform and should be provided opportunities to comment on the Waiver through a public process. Note that the November 2001 and August 2002 submissions included a "premium proposal" very similar to the one herein. Prior to the August 2002 submission, DSHS conducted an extensive public process with two goals:

- First, to make available information for all those interested in learning about the Waiver; and,

- Second, to afford all interested parties an opportunity to provide input prior to its submission.

It is the Department's belief that the public process conducted during this period more that adequately met the public needs for timely and accurate information and input.

B. Public Notice and Media Release

On May 14, 2002, DSHS made available to all local written media a news release that declared its intent to submit an amended Waiver to CMS. The news release was carried in papers of general circulation. It also provided a means by which interested parties could learn more about these activities and provide feedback, including the address of the Waiver website and telephone numbers of MAA staff working on the project.

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[9] ***Washington State Planning Grant on Access to Health Insurance, Proposal for Additional Funding***, Governor's Executive Policy Office, Office of Financial Management, July 14, 2003.

To increase public awareness about the Waiver, DSHS sent over 1,500 notices to stakeholders across the state. Stakeholders included clients, providers, and advocacy groups. The notice informed the public of DSHS' intent to submit an amended Waiver, how to find out more information about the Waiver, and announced the ten Town Hall meeting locations, dates, and times.

C. Town Hall Meetings

Beginning on May 21, 2002, DSHS held its first of ten Town Hall meetings. Each meeting was scheduled from 6:00 to 9:00 p.m. to provide a more convenient meeting time for local residents. The first portion of the three-hour presentation was used to provide a PowerPoint presentation that outlined the budget perspective and major elements of the proposed Waiver: co-payments, premiums, benefit design, an enrollment freeze, and SCHIP expansion. The remaining two hours were used to elicit comments, suggestions and questions from the audiences. The information obtained from each Town Hall meeting was documented by DSHS staff and subsequently posted for review on the Waiver website. Moreover, local newspapers reported on the town hall meetings in their communities. Follow-up articles appeared in the Tacoma News Tribune, the Longview Daily, the Seattle Post-Intelligencer, the Seattle Times, the Spokane Spokesman Review, the Olympian, the Tri-City Herald, the Yakima Herald-Republic, the Bellingham Herald, the Everett Herald, and the Port Angeles Daily.

The ten Town Hall meeting dates and locations were: Spokane, May 21; Olympia, May 22; Tacoma, May 28; Bellingham, May 30; Port Angeles, June 5; Seattle North, June 6; Pasco/Kennewick, June 11; Yakima, June 12; Vancouver, June 18; Seattle South, June 20.

D. Feedback Process

As a tool to encourage input, a feedback form was developed and distributed at each Town Hall meeting. The form sought feedback pertaining to the four key provisions of the Waiver: copayments, premiums, benefit design, and an enrollment freeze. For simplification, the form was a self-addressed prepaid folder that could be filled out, stapled, and mailed. DSHS received more than 100 forms with responses varying from nonsupportive to supportive.

DSHS collected many suggestions and comments during the ten Town Hall meetings and via the Waiver website from the last week of April through the end of June 2002. Suggestions and comments were given consideration while writing the amended Waiver. Where appropriate, suggestions and comments were incorporated into the Waiver. However, most statements were of a general nature either in support of or against the major provisions of the Waiver - namely, co-payments, premiums, changes in benefits, and an enrollment freeze. On July 22, 2002, the draft Waiver using the HIFA template was disseminated to stakeholders for review before formal submission to CMS.

E. Waiver Website

To provide additional information and to allow another means by which interested parties could provide feedback, DSHS continued maintenance of the Waiver website at http://maa.dshs.wa.gov/medWaiver. On the site, interested parties could review and download a four-page fact sheet that outlined the major elements of the Waiver, a PowerPoint presentation that was given at the ten Town Hall meetings, and Town Hall meeting notes from each Town Hall meeting. Additionally, interested parties were encouraged to read through the Waiver documents and send electronic comments via the website. DSHS received over 100 messages.

F. Government-to-Government Consultation

On May 2, 2002, an official notice was sent to the 29 tribes in the State of Washington requesting a meeting to be held on June 4, 2002. Tribes in Washington were notified of DSHS' intent to submit an amended Waiver and provided information on those elements of the Waiver that may impact the tribes and their members. The meeting was attended by representatives from ten tribes, the Governor's Health Policy Advisor, the Assistant Secretary of MAA, and other MAA staff. At the consultation, the tribes expressed a desire to review the completed draft Waiver and to meet again to discuss it. State staff agreed and met with the tribes on July 29, 2002, at the American Indian Health Commission. MAA staff also made several presentations before the DSHS Indian Policy Advisory Committee on the Waiver's provisions and its potential impact on Washington's tribes.

G. Future Communications and Stakeholder Interaction

As the State proceeds with the Waiver re-submission and implementation, the following activities will provide stakeholders with updates and opportunities for input:

- Bi-monthly meetings of the Title XIX Advisory Committee.
- Quarterly meetings with medical directors of health carriers that contract with the state, jointly sponsored by the contracting state health agencies.
- Quarterly meetings with administrators of health carriers that contract for Healthy Options, sponsored by MAA.
- Periodic meetings with provider and client advocate groups.
- Frequent presentations upon request by interested parties.
- The DSHS Secretary's focus groups held annually throughout the state.
- MAA's strategic planning process.
- MAA's Waiver website.

XVI. IMPLEMENTATION

A. Timeline

As indicated above, the 2003-2005 Biennial Budget Act directs DSHS to obtain the Waiver by September 1, 2003.

The program is scheduled to commence in January 2004.

First premium to be collected in February 2004.

B. MAA Staff Training:

Training programs will be presented to local eligibly office workers and their supervisors in advance of the demonstration's implementation. Affected MAA staff will have access to a DSHS Internet website where information and answers to "Frequently Ask Questions (FAQs) are available.

C. Client Education*:*

To assure clients, current and future, have the information and support needed to understand premiums and how premium payment ties to maintaining medical coverage, a wide variety of education strategies will be implemented to target clients, community stakeholders, and state toll-free and eligibility staff. All materials, including applications, inserts, flyers, and invoicing, will be translated into seven languages.

Education activities will address pre-and post-implementation issues and will begin four to six months prior to implementation. Potential strategies during this time period are:

- An insert in medical applications notifying clients about upcoming changes and what to look for.
- Computerized letters explaining premiums, sent or given upon eligibility determination.
- Targeted client mailings emphasizing the importance of timely payment and return of eligibility reviews.
- Notification insert in the monthly Medical Assistance Identification card.
- Creation and marketing of a dedicated website with a FAQ, press releases, copies of provider and client mailings, and other educational materials to keep communities, staff, and clients informed.
- Message on the Medical Assistance client and provider toll-free lines advising callers that premiums will be implemented and where to get more information.

D Provider Education

MAA, at present, has a comprehensive program of provider relations, which includes not only timely dissemination of information, but also staff available for direct, real- time Provider to MAA contacts. Providers will be apprised of the Waiver through that on-going process.

E Legislative Oversight and Reports

Since implementation of the Waiver is part of the Legislature's plan to improve the efficiency of publicly funded health care programs, member interest is high. At present, the following oversight activities and reports are planned:

- A public work session before the health care committees in November 2004 to review implementation plans.
- Quarterly briefings of key legislators during 2004.
- Testimony provided upon request of committee chairs, and
- A written status report submitted to the Governor and Legislature and released to the public in December 2004.

Subsequent reports and presentations will be scheduled upon the completion of the Waiver evaluation plan, and with further consultation with the health care committee chairs.

XVIII WASHINGTON HEALTH RELATED STAKEHOLDERS

Providers and Facilities:

Acupuncture Association of WA
Advanced Registered Nurse Practitioners
American Academy of Pediatrics, WA Chapter
American Association of Massage Therapy, WA Chapter
Association of WA Public Hospital Districts
Midwives Association of WA State
National Association of Chain Drug Stores
Opticians Association of WA
Optometric Physicians of WA
Pharmacists of WA
Physical Therapy Association of WA
Respiratory Care Society of WA
School Nurses Organization of WA
WA Mental Health Counselors Association
WA Academy of Physician Assistants
WA Ambulance Association
WA Association Community and Migrant Health Centers
WA Association of Diabetes Educators
WA Association of Naturopathic Physicians
WA Association of Nurse Anesthetists
WA Chapter of the American College of Emergency Physicians
WA Community Mental Health Council
WA Dental Service
WA Occupational Therapy Association
WA Osteopathic Medical Association
WA Podiatric Medical Association
WA State Chiropractic Association
WA State Dental Association
WA State Hospital Association
WA State Medical Association
WA State Nurses Association
WA State Pharmacists Association
WA State Psychiatric Association
WA State Psychological Association
WA State Rural Health Association
WA Wholesale Druggist Association

Insurers and Third Party Administrators:

Administrators West
Association of WA Healthcare Plans
Community Health Plan of WA

Complementary Healthcare Plans
Group Health Cooperative
Health Insurance Association of America
Kaiser Permanente Health Plan
Magellan Health Services
Molina Health Care of WA
Northwest Administrators
Pacificare of WA
Peacehealth
Premera Blue Cross
Regence Blue Shield
WA Association of Health Underwriters
WA State Medical Group Mgmt Association
WA Farm Bureau

Advocacy Groups:

American Association of Retired Persons
American Cancer Society
American Heart Association
American Lung Association of **WA**
American Diabetes Association
American Society for Bariatric Surgery
Children's Alliance
Columbia Legal Services
Empower Alliance
Friends of Basic Health
Northwest Federation of Community Organizations
Northwest Health Law Advocates
WA Citizen Action
WA State Coalition of Mental Health Professionals and Consumers
WA State Trial Lawyers Association
WA Senior Citizens Lobby

Indian Tribes:

American Indian Health Commission
Chehalis Confederated Tribe
Confederated Tribes of the Colville Reservation
Cowlitz Indian Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Lower Elwha Klallam Tribe
Lummi Indian Nation
Makah Tribe
Muckleshoot Tribe
Nisqually Tribe

Nooksack Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Nation
Samish Tribe
Sauk-Suiattle
Shoalwater Bay Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
The Tulalip Tribes
Upper Skagit Tribe
Yakama Nation

Health Care Manufacturers and Suppliers:

Astrazeneca Pharmaceuticals
Consumer Healthcare Products Association
Glaxo Smithkline
Johnson & Johnson
Merck & Co Inc
Pacific Association of Medical Equipment Supplier
Pharmaceutical Research and Mfg. of America (PhRMA)
Schering-Plough External Affairs, Inc
WA Hearing Healthcare Providers
WA Orthodontic & Prosthetic Association

Businesses and Private Purchasers:

Association of WA Business
Employer Healthcare Coalition
Independent Businesses of WA
National Federation of Independent Businesses
The Forum For Health Reform
WA State Health Care Purchasers Alliance

Local Government:

WA Association of Local Public Health Officers
WA Association of Counties
Association of WA Cities
Regional Support Networks

XVIII. EXHIBITS & TABLES

Exhibit A Medicaid CN Non-Grant Children
Exhibit B Medicaid Premium Estimates and Caseload Impact
Exhibit C Medicaid Premium Estimates And Caseload Impact
Table One Medical Assistance Program's May 2003 Caseload
Table Two Medicaid Categorically Needy Children
Table Three Data Collection for Monitoring Waiver Implementation
Table Four Expenditures by Service Optional Non-Grant Eligible Children